

Return this completed enrollment packet to:

EDS Provider Enrollment

PO Box 23

Boise, ID 83707

Phone: (208) 383-4310; Toll-free: (800) 685-3757

Fax: (208) 395-2198

DO NOT WRITE HERE

Enrollment Tracking #: _____

Sanction _____ DUPL _____ New _____ ReEn _____

EDS: _____ Entered: _____ Effective: _____

Provider #: _____

Type: **010** Specialty: _____ **0** Ind **PPI A**

Pend _____ Email _____

**Idaho Medicaid Provider Enrollment Packet
Non-Emergency Transportation**

Welcome to the Idaho Medicaid Program. This enrollment packet has been prepared for use by non-emergency transportation service providers. These include individual drivers (often family members), transportation companies (such as buses and taxicabs), service agencies (businesses that provide other services to Medicaid participants), and hospitality industry providers (such as travel agents, car rental agencies, motels, and restaurants).

To complete the application process, you will need the following documents. Except for the attachments, all of these documents are included in this enrollment packet. See the instructions in Part 3 for information on attachments.

_____ **Non-Emergency Transportation Provider Application** (Part 1)

_____ **Additional Documentation** (Part 2)

_____ **Medicaid Provider Agreement** (Part 2)

_____ **Supplemental Transportation Provider Agreement** (Part 2)

_____ **Signature-on-File form** (Part 2, Optional)

_____ **Authorization for Electronic Funds Transfer form** (Part 2, Optional)

_____ **Electronic Claims Submission form** (Part 2, Optional)

_____ **Disclosure of Ownership and Control Interest Statement**
(Required of all specialties except Individual transportation)

_____ **Attachments** (Part 3)

_____ **W-9 form** (Required)

Before you begin filling out this enrollment packet, first complete the W-9 form (Request for Taxpayer Identification Number and Certification) that is included at the end of the packet. This is a four page form that includes directions for completion. It must be signed and dated by the provider. You will use the name, address, and tax identification number entered on the W-9 form to complete this application. The name on the W-9 form is the name under which you report to the IRS. It is the same name used for the Pay-to address on page 3 of the application. It must be signed and dated by an authorized representative of the provider. This form is required.

Once you have assembled and completed all of the required materials, take a moment to check off each of the pieces listed above. Incomplete applications are returned to the provider. Take a second look to be sure that you have remembered to date and sign all forms.

Make a copy of this enrollment packet for your records. Send the original to EDS at the address found on the top of this page. If you have questions about the status of your application, and you received this application from EDS, use the enrollment tracking number written at the top of this page, and call EDS Provider Enrollment at: (208) 383-4310 or (800) 685-3757.

Note: The effective date of this enrollment will be no earlier than the first date it was received at EDS or the Idaho Department of Health and Welfare.

Note: Do not include claims with this enrollment packet. They will be returned.

All forms must be completed in black ink.

1. **Provider Name and Primary Service Location:** This is the name and address that the provider will use to submit claims. This name is also entered on the Medicaid Provider Agreement in Part 2 of this enrollment packet. The address is the physical address of the individual or business. While you may include a post office box, you must use a street address. If you have additional service locations, enter them on page 3, Additional service locations.

Name: _____

Street Address: _____

City: _____ **State:** _____ **Zip+4:** _____

Phone: () _____ **Email:** _____

Mailing Address for this physical location (if different from above)

Street Address: _____

City: _____ **State:** _____ **Zip+4:** _____

Phone: () _____ **Email:** _____

2. **Medicaid Participation:** Have you been an Idaho Medicaid provider at any time in the past?

YES NO

3. **Federal Employer Identification Number (FEIN):** You may use either a Social Security Number (SSN) or FEIN as a tax identification number. Whichever number is used, it must match the number on the W-9 form.

FEIN Number: _____

4. **SSN:** You may use either a SSN or FEIN as a tax identification number. Whichever number is used, it must match the number on the W-9 form.

SSN: _____

5. **Remittance Advice (RA):** When you begin to bill Medicaid for claims, you receive a RA every week that you have a claim in the system. The RA explains the status of your claim. On this application, you are asked if you want to have pended claims included on your RA. A pended claim is a claim that has not been paid or denied but is being held for further review. Select YES if you want to be informed of the status of pended claims.

Do you want pended claims information printed on your RA?

YES NO

- 6. Provider Specialty:** All Medicaid providers are identified by provider specialty. Refer to the provider specialty list and select the specialty that best describes the service you will be rendering.

Select only one specialty description.

Select	Code	Specialty	Description
	109	Commercial transportation (non-emergent)	Advertises and provides transportation to the general public. Has an established rate schedule. Serves all people in the community, as well as Medicaid participants. Examples are cab and bus companies. Also includes members of the hospitality industry such as travel agencies, motels, restaurants, and car rental agencies. Note: Please complete the Driver and Vehicle Rosters for Commercial Transportation Providers, pages 4 and 5 of this application.
	110	Individual transportation	Drives a limited number of Medicaid participants, often a family member. Examples are parents or children of Medicaid participants.
	111	Agency transportation	Provides transportation to Medicaid participants served by the agency. Examples are treatment centers, hospitals, nursing homes, and personal care service agencies.
6a.	Idaho Medicaid provider number:		Agency transportation providers must include the Idaho Medicaid provider number for their agency services.

- 7. Name, Address, Telephone, and Email:** Providers may have different addresses and telephone numbers for different purposes. The Pay-to name and address may be the same as the Provider Name and Primary Service Location used on page 1 of Part 1.

Pay-to (required)

PRAD01

This is the name that will appear on your check and is reported to the IRS. It must match the name entered on the W-9 form. Checks and RA will be mailed to this address. This is a required field.

Name: _____

Street address: _____

PO Box: _____

City: _____ State: ____ Zip: _____

Phone: (_____) _____

Email: _____

Mail-to address (optional)

PRAD02

This is the name and address where correspondence is mailed including newsletters, provider handbooks, and updates. The Pay-to name and address will be used if the Mail-to address is left blank. This is an optional field.

Name: _____

Street address: _____

PO Box: _____

City: _____ State: ____ Zip: _____

Phone: (_____) _____

Email: _____

Billing service address (optional)

PRAD03

This is the name and address that is used if a billing service handles your claims.
This is an optional field.

Name: _____

Street address: _____

PO Box: _____

City: _____ State: ____ Zip: _____

Phone: (_____) _____

Email: _____

Contact address (optional)

PRAD13

This is the name and address used for the specific person to be contacted for questions about claims if it is different from the provider.
This is an optional field.

Name: _____

Street address: _____

PO Box: _____

City: _____ State: ____ Zip: _____

Phone: (_____) _____

Email: _____

Additional service location(s) (optional)

PRAD04

This is the name and address of additional service locations that the provider will use to submit claims. While you may include a post office box, you must use a street address.

Name: _____

Street address: _____

PO Box: _____

City: _____ State: ____ Zip: _____

Phone: (_____) _____

Email: _____

If there are additional service locations please list them on a separate piece of paper.

Vehicle Roster – Commercial Transportation Provider

This roster is required for commercial transportation providers (provider type 010, specialty 109). Please enter the make, model, year, and VIN for each vehicle used to transport Idaho Medicaid participants. Do not include vehicles that will not be used to furnish Medicaid services.

If more space is needed, copy this page, and complete the listing. Include a legible copy of the current vehicle registration for each vehicle on this roster.

[illegible]

Additional Documentation

Included in this enrollment packet are seven additional documents. To complete this application you must:

- A.** Read, sign, and date the Medicaid Provider agreement. At the top of the form, enter the same name for the provider as you entered for the Provider Name and Primary Service Location on page 1 of the application. This form is required.
- If an individual is enrolling as a provider, enter the person's name at the top of the form. The individual must sign and date this agreement. No other person can be authorized to sign for an individual provider.
 - If a business, group, or agency is enrolling as a provider, an authorized agent must sign and date this agreement.
- B.** Read, complete, sign, and date the Supplemental Transportation Provider Agreement. In this supplemental agreement, individual and agency transportation providers are considered "non-commercial". This form is required for all providers.
- On page 1 of this Supplemental Transportation Provider Agreement, enter the same name and address as you entered in field 1 of the Non-Emergency Transportation Provider Application.
 - On page 2 of this Supplemental Transportation Provider Agreement, initial the type of services you will be providing. Select only one.
 - On page 5 of this supplemental agreement, complete the fields below, "For the Provider"
 - If a person is enrolling as an individual provider, that person must sign and date this Supplemental Transportation Provider Agreement. No other person can be authorized to sign for an individual provider.
 - If a business, group, or agency is enrolling as a provider, an authorized agent must sign and date this Supplemental Transportation Provider Agreement.
- D.** When submitting paper claims, providers must sign every claim form or complete a Signature-on-File form. If you wish to submit claims without a handwritten signature, complete the Signature-on-File form. This form allows submission of paper claims without a handwritten signature by using a stamp or the notation, Signature-on-File. This form is optional.

Indicate the exact notation that will be used on paper claim forms in the provider signature field. This can be the name of an individual (e.g., Ima Driver), a business (e.g., Transport, Incorporated), or Signature-on-File. Once the Signature-on-File form is received by EDS:

- No other notation will be accepted as a valid signature on claims.
 - The provider accepts responsibility for all claims submitted with the notation from the Signature-on-File form.
- E.** Complete the Authorization of Electronic Funds Transfer form if you wish to have your payments automatically deposited to your banking account. This form is optional.

- F.** Complete the Electronic Claims Submission Certification and Authorization form if you wish to bill electronically. This form is optional.
- G.** Complete, sign, and date the Disclosure of Ownership and Control Interest form. This form is required of all specialties listed on page 2 of the Non-Emergency Transportation Provider application, except Individual Transportation.
- H.** Complete the four page W-9 form found at the back of this packet. Follow the instructions on the W-9 form. The name on the W-9 form is the name under which you report to the IRS. The name on the W-9 form is the same name used for the Pay-to address on page 3 of the application. Date and sign the form. This form is required.

Idaho Department of Health and Welfare Medicaid Provider Agreement

Name and address of individual or entity applying to provide these items or services:

Current or previous provider number for this provider type and specialty: _____

(Does not apply if this is an initial application)

As a condition of participation in Medicaid, the provider agrees as follows:

1. Compliance

To provide services in accordance with all applicable federal laws, and provisions of statutes, state rules, and federal regulations governing the reimbursement of services and items under Medicaid in Idaho, including *IDAPA 16.03.09, Medicaid Basic Plan Benefits, IDAPA 16.03.10, Medicaid Enhanced Plan Benefits, IDAPA 16.03.13, Consumer Directed Services, IDAPA 16.03.17, Medicare/Medicaid Coordinated Plan Benefits, and IDAPA 16.03.18, Medicaid Cost Sharing*, as amended; the current applicable *Medicaid Provider Handbook*; any Additional Terms attached hereto and hereby incorporated by reference; and any instructions contained in provider information releases or other program notices.

- 1.1. To comply with the Health Insurance Portability and Accountability Act (HIPAA), §§ 262 and 264 of Public Law 104-191, 42 USC § 1320d, and federal regulations at 45 CFR Parts 160 and 164. The provider shall comply with all amendments of HIPAA and federal regulations made during the term of the Contract. The provider specifically acknowledges its obligation to comply with 45 CFR Section 164.506, regarding use and disclosure of information to carry out treatment, payment or health care operations.
- 1.2. To protect the confidentiality of identifying participant information that is collected, used, or maintained according to *IDAPA 16.05.01, Use and Disclosure of Department Records*, and 42 CFR § 431.300.
- 1.3. To comply with the False Claims Act (31 USC 3729-3733). Any provider who either receives or makes annual Medicaid payments of at least five million dollars (\$5,000,000) shall comply with 42 USC § 1396(a)(68). The provider specifically acknowledges the responsibility regarding employee education about the False Claims Act and state laws pertaining to civil or criminal penalties for false claims and statements and whistleblower protections under such laws.
- 1.4. To comply with Titles VI and VII of the 1964 Civil Rights Act and Sections 503 and 504 of the Rehabilitation Act of 1973, as amended, the Americans with Disabilities Act, and Section 402 of the Vietnam Era Veterans Readjustment Assistance Act.
- 1.5. To comply with the disclosure of ownership requirements in 42 CFR § Part 455, Subpart B, and 42 CFR § 411.361, when applicable, and to notify the Department of Health and Welfare (IDHW) 30 days prior to any change of ownership. This Provider Agreement is not transferable.
- 1.6. To comply with the advance directives requirements of 42 CFR Part 489, Subpart I, and 42 CFR § 417.436(d), when applicable.

2. Contact

To advise IDHW of the provider's current mailing address. If a PO Box is used, the owner's home address and phone number must be included. All correspondence sent to the mailing address on file with the state's fiscal agent shall be deemed to have been received by the provider.

3. Professionalism

To be licensed, certified, or registered with the appropriate state authority and to provide items and services in accordance with statute, rules, and professionally recognized standards by qualified staff or professionally supervised paraprofessionals where their use is authorized. The provider shall respect the Medicaid participant's right to privacy, dignity, and free choice of provider.

4. Recordkeeping

To document each item or service for which Medicaid reimbursement is claimed, at the time it is provided, in compliance with documentation requirements of Idaho Code, § 56-209h(3), as amended, applicable rules, and this agreement. Such records shall be maintained in hard copy for at least five years after the date of services or as required by rule. In compliance with 42 CFR 1001.1301, IDHW, the Medicaid Fraud Control Unit of the Office of the Idaho Attorney General, the U.S. Department of Health and Human Services, or their agents, shall be given immediate access to, and permitted to review and copy any and all records relied on by the provider in support of services billed to Medicaid.

5. Accurate Billing

To certify by the signature of the provider or designee, including electronic signatures on a claim form or transmittal document, that the items or services claimed were actually provided and medically necessary, were documented at the time they were provided, and were provided in accordance with professionally recognized standards of health care, applicable Department rules, and this agreement. The provider shall be solely responsible for the accuracy of claims submitted, and shall immediately repay IDHW for any items or services IDHW or the provider determines were not properly provided, documented, or claimed. The provider must assure that a duplicate claim under another program or provider type is not submitted.

6. Secondary Payer

To acknowledge that Medicaid is a secondary payer and to seek payment first from other all sources as required by rule, regulation, or statute, before billing Medicaid. The provider shall not refuse to furnish services on account of a third party's potential liability for the services. (42 CFR § 447.20)

7. Payment

To accept Medicaid payment for any item or service as payment in full and to make no additional charge except that specifically allowed by Medicaid. The provider further agrees:

- 7.1. To submit requests for prior authorization, if required, before the item or service is provided. The provider agrees not to bill Medicaid if a required request for prior authorization is not timely submitted.
- 7.2. Not to bill the participant unless the item or service is not covered by Medicaid, and the participant has agreed to be responsible for payment prior to receiving the item or service.
- 7.3. That if a third party pays the participant, the participant may be billed for that amount, and Medicaid will not be billed.
- 7.4. Not to bill Medicaid or the participant if a third party payment is made to the provider unless the third party payment is less than the amount Medicaid would pay.

8. Service Providers

To be responsible for the recruiting, hiring, firing, training, supervision, scheduling, and payroll for its employees, subcontractors, or agents. The provider shall maintain general liability insurance coverage, worker's compensation, and unemployment insurance, and shall pay all FICA taxes and state and federal

tax withholding for its employees. The provider agrees to bill only for service providers who have the qualifications required for the type of service that is being delivered.

9. Officers and Employees Not Liable

No official, employee, or agent of the State of Idaho shall be in any way personally liable or responsible for any term of this agreement, whether express or implied, nor for any statement, representation, or warranty made in connection with this agreement.

10. Duration and Termination of Agreement

This agreement shall remain in effect until terminated in writing. In the event of termination, IDHWs sole obligation shall be to pay for services provided prior to the effective date of termination. The IDHW shall not be responsible for any costs or expenditures of the provider in reliance upon the terms of this agreement.

- 10.1. This agreement may be terminated by either party without cause by giving 30 days notice in writing to the other party.
- 10.2. This agreement shall be terminated if judicial interpretation of federal or state laws, regulations, or rules renders fulfillment of the agreement infeasible or impossible.
- 10.3. This agreement shall be terminated immediately if the provider's license or certification required by law is suspended, not renewed, or is otherwise not in effect at the time service is provided.
- 10.4. The IDHW may, in its discretion, terminate this agreement in writing when the provider fails to comply with any applicable rule, term, or provision of this agreement, either immediately or upon such notice as IDHW deems appropriate. The provider also understands and agrees that its conduct may be subject to additional penalties or sanctions under Idaho Code §§ 56-209h, 56-227, 56-227A, 56-227B, and 56-227E, and *IDAPA 16.05.07, The Investigation and Enforcement of Fraud, Abuse and Misconduct*, as amended. The provider further understands that there are federal penalties for false reporting and fraudulent acts committed during the course and scope of this agreement. Notice of these sections shall in no way imply that they represent an exclusive or exhaustive list of available actions to deal with fraud and abuse.

11. Provider Liability

If the provider is any type of partnership, corporation or nonprofit entity, the provider agrees that the entity and the partners, directors, officers, members, or individuals with an ownership interest of 5 percent or greater, are jointly and severally liable for any breach of this provider agreement, and that action by IDHW against the provider may result in action against all such individuals in the entity.

12. Additional Terms, if any, are provided in Appendix A, attached.

I have read the foregoing provider agreement, understand it and agree to abide by its terms and conditions. I further understand and agree that violation of any of the terms and conditions of this agreement constitute sufficient grounds for termination of this agreement and may be grounds for other action as provided by state rule, federal regulation, or statute.

Printed name of individual practitioner or individual authorized to sign on behalf of the provider:

Position: _____

By my signature, I declare, under penalty of perjury, that I have the legal authority to enter into this agreement and hereby bind all entities and individuals that comprise the provider.

Signature

Date

**State of Idaho Department of Health and Welfare (IDHW)
Medicaid Provider Agreement for Commercial and
Non-Commercial Non-Emergency Transportation**

This Medicaid Provider agreement is made and entered into by and between the IDHW, hereinafter designated as the department, and a provider of transportation services, hereinafter designated as the provider.

(Name of Provider)

(Address of Provider)

The purpose of this Medicaid Provider agreement is to provide medically necessary non-emergency transportation services to eligible Medicaid participants in accordance with the Rules Governing Medical Assistance, *IDAPA 16.03.09. et. seq.*

1. Definitions:

1.1. Agency Transportation Provider: Shall mean any of the following:

- 1.1.1.** An entity whose employees or agents provide transportation services in addition to one or more other services to the same Medicaid participant or participants.
- 1.1.2.** An entity whose employees or agents transport Medicaid participants to or from another Medicaid service in which the entity has ownership or control.
- 1.1.3.** An entity whose employees or agents transport Medicaid participants pursuant to an arrangement that is not an arm's length transaction.

1.2. Attendant: Shall mean an individual, other than the driver or a participant's family member, who accompanies a Medicaid participant to medical services if deemed necessary due to the participant's age, other mental or physical conditions.

1.3. Commercial Transportation Provider: Shall mean an entity in the business of transportation that is organized to provide, that publicly holds itself out to provide, and that actually provides personal transportation services to the general public. By "holding itself out" to the general public, the provider vigorously and diligently solicits riders from the general populace. By "actually providing" services to the general public, the provider's ridership includes substantial numbers of persons whose travel is funded by a source other than Medicaid.

1.4. Department: Shall mean the IDHW as represented by the Director or their official designee.

1.5. Incidental Services: Shall mean necessary and approved meals, lodging, attendants, or other necessary services which are prior approved by IDHW and are incidental to the transport of a Medicaid participant as specified in the Rules Governing Medical Assistance, *IDAPA 16.03.09.151.03.*

1.6. Individual Transportation Provider: Shall mean any individual who does not meet the definition of a commercial transportation provider and provides only transportation services or incidental services to a Medicaid participant.

1.7. Non-Commercial Transportation Provider: Shall mean any transportation provider that does not meet the definition of a commercial transportation provider. Non-commercial transportation services may be performed by an agency or independent provider. The provider will be considered a non-commercial transportation provider if the Medicaid participants being transported are also participants of the provider for services such as residential care, mental health, developmental disability, or other Medicaid and non-Medicaid services. Additionally, the provider will be considered a non-commercial transportation provider if the participants are receiving services from, or

being transported to, services for which the provider has any ownership, control, or related party interests in one or more of the residential care, transportation, or the Medicaid services to which the participant is being transported.

1.8. Non-Emergency Transportation Provider: Shall mean transportation as described in the Rules Governing Medical Assistance, *IDAPA 16.03.09.151* and *152*.

1.9. Non-Medical Transportation: Means individual assistance with non-medical transportation services as described in the Rules Governing Medical Assistance, *IDAPA 16.03.09.677*.

1.10. Provider: Shall mean the individual, agency, or entity providing services pursuant to this agreement.

2. Service Delivery:

2.1. The services furnished by a provider for which payment may be made by the State Title XIX (Medical Assistance) program are those defined in the Rules Governing Medicaid Basic Plan Benefits, *IDAPA 16.03.09 et. seq.*

2.2. The conditions and restrictions in this Medicaid Provider agreement are intended to protect eligible Medicaid participants and assure that services are provided in a professional manner in accordance with state and federal law.

2.3. The provider acknowledges the scope of services delivered and reimbursed by Medicaid will be for the type of provider services as defined in this Medicaid Provider agreement and the Rules Governing Medicaid Basic Plan Benefits.

_____ Individual transportation provider

_____ Agency transportation provider

_____ Commercial transportation provider

(Indicate provider type above with initials. Provider may only select one providers type for this Medicaid Provider agreement. If more than one provider type applies, each must be designated on a separate Non-Emergency Transportation Provider application and Medicaid Provider agreement).

3. Department Responsibilities:

The Idaho Department of Health and Welfare agrees to pay the provider for necessary non-emergency transportation services provided to eligible Medicaid participants, to Medicaid covered services, in accordance with applicable state and federal law, the Rules Governing Medicaid Basic Plan Benefits, and this Medicaid Provider agreement. Payment will be made in accordance with a rate established or approved by IDHW.

4. Provider Responsibilities:

4.1. Provider agrees to only bill Medicaid for the amount and scope of services actually rendered or authorized by IDHW, and in accordance with this Medicaid Provider agreement, the Rules Governing Medical Assistance, and the *Idaho Medicaid Provider Handbook*. The provider understands that payment for services is derived from state and federal funds in accordance with Title XIX of the Social Security Act, and that any false, misrepresented, or improperly submitted claims may be subject to criminal, civil, and administrative remedies as allowed by state and federal law.

4.2. Provider agrees that Medicaid reimbursement for incidental services such as meals, lodging, attendant care, and other necessary incidental services will only be made when prior approved by IDHW, and as defined in the Rules Governing Medicaid Basic Plan Benefits, *IDAPA 16.03.09.151.03*. providers who bill Medicaid for incidental services agree to maintain records and receipts sufficient to support the costs and the extent of the services rendered.

4.3. Provider agrees to ensure the safety and well being of all participants transported, and agrees to maintain and operate vehicles in a manner which ensures protection of the health and safety of participants transported.

4.4. Provider agrees to maintain records in accordance with the Rules Governing Medicaid Basic Plan Benefits, Section 56-209h Idaho Code and this agreement for a period of five years. The provider agrees to make records available upon request, and provide immediate access of records for inspection, review, and copying by IDHW, the US Department of Health and Human Services, or any other authorized personnel.

4.5. The provider agrees to accept Medicaid payment as payment in full for services delivered to Medicaid participants. The provider agrees not to charge Medicaid participants for any services covered by the Medicaid program.

4.6. The provider agrees to immediately refund to the Medicaid program, the amounts paid for any services for which required documentation was not retained and provided upon request, or for which payment was made in violation of this Medicaid Provider agreement, the *Idaho Medicaid Provider Handbook*, or the Rules Governing Medicaid Basic Plan Benefits.

4.7. The provider agrees that department prior authorization only authorizes the provider to perform Medicaid covered services for an eligible Medicaid participant but does not guarantee payment. Reimbursement is subject to review to ensure billed and paid services were rendered, were medically necessary, and were provided in accordance to the Rules Governing Medicaid Basic Plan Benefits, the *Idaho Medicaid Provider Handbook*, and this Medicaid Provider agreement.

5. Commercial Transportation Providers:

5.1. Provider agrees to only bill Medicaid for services delivered pursuant to the established minimum qualifications for non-emergency transportation providers. The minimum qualifications are:

5.1.1. Maintain all certifications and licenses for drivers and vehicles required by all public transportation laws, regulations, ordinances that apply to the transportation provider.

5.1.2. Adhere to all laws, rules, and regulations applicable to transportation providers of that type, including those requiring liability insurance. Liability insurance will be carried in an amount to cover at least \$500,000 personal injury and \$500,000 property damage per occurrence.

5.1.3. Enter into a Medicaid Provider Agreement and enrollment application.

5.2. Commercial transportation providers performing fixed route and demand response door to door services will maintain records sufficient to support the amount and scope of services performed and billed to include:

5.2.1. Prior authorization documents.

5.2.2. Date, time, and geographical point of pick-up for each participant.

5.2.3. Date, time, and geographical point of drop-off for each participant.

5.2.4. Mileage each participant was transported for each trip billed.

5.2.5. Identification of the vehicle(s) and driver(s) transporting each participant on each trip.

5.3. Commercial transportation providers providing fixed route and demand response door to door services will report annually, data sufficient to determine amount and costs of services performed as defined by IDHW.

5.4. Commercial transportation providers providing fixed route and demand response door to door services agree to only bill IDHW for services which are prior authorized

by IDHW and pursuant to fare schedules approved by IDHW. The provider agrees to notify IDHW in writing 30 days prior to any changes in rates or fares.

5.5. Commercial transportation providers performing taxi services, airline services, rental car services, and lodging will maintain records sufficient to support the amount and scope of services performed and billed to Medicaid.

5.6. Commercial transportation providers performing taxi services, airline services, rental car services, meals, and lodging agree to only charge Medicaid an amount approved by IDHW, and an amount not to exceed the provider's charge to the general public.

6. Non-Commercial Transportation Providers:

6.1. Non-commercial transportation providers agree to, at a minimum, the following standards:

6.1.1. Continuously maintain liability insurance that covers passengers. For agency providers, coverage must be at least one-hundred thousand (\$100,000) per individual and three-hundred thousand (\$300,000) each incident. Individual providers must carry at least the minimum liability insurance required by Idaho law. If an agency permits employees to transport participants in employees personal vehicles, the agency must ensure that adequate liability insurance coverage is carried for those circumstances.

6.1.2. Obtain and maintain all licenses and certifications required by the government to conduct business and to operate the types of vehicles used to transport participants.

6.1.3. Adhere to all laws, rules, and regulations applicable to drivers and vehicles of the type used. Agency providers shall maintain documentation of appropriate licensure for all employees who operate vehicles.

6.1.4. Enter into a Medicaid provider enrollment application and agreement.

6.2. Non-commercial transportation providers performing non-emergency transportation services will maintain records sufficient to support the amount and scope of services performed and billed to include:

6.2.1. Participant name and Medicaid number for each trip.

6.2.2. Date, time, geographical point at pick-up, and odometer reading at pick-up for each participant trip.

6.2.3. Date, time, geographical point at drop-off, and odometer reading at drop-off for each participant trip.

6.2.4. Mileage each participant was transported for each trip billed.

6.2.5. Identification number of the vehicle and driver transporting each participant on each trip.

6.2.6. Notice of prior authorization, when required.

6.3. The provider agrees to maintain documentation sufficient to support the total number of riders being billed to Medicaid. Services billed where documentation is insufficient to support the number of riders being transported will be subject to recoupment, or other action as allowed by state or federal law.

6.4. Individual providers agree to bill only for services they personally perform.

7. General Provisions:

7.1. Notices: The provider agrees to notify IDHW in writing of any change of address. Notices sent to the provider to the address on file will be presumed to have been received by the provider.

7.2. Information Requests: The provider will submit within 35 days of the date of the request by the Secretary of the U.S. Department of Health and Human Services, their designee, or IDHW, full and complete information as required by 42 C.F.R. Section 455-104 through 455.106, to include:

7.2.1. The ownership of any subcontractor with whom the provider has had business transactions.

7.2.2. Any business interest of the provider and its owners or employees that provides services to any eligible Medicaid participants.

7.3. Termination: The Idaho Department of Health and Welfare may terminate this Medicaid Provider agreement for cause, or without cause, as stated below.

7.3.1. Termination for Cause:

7.3.1.1. The Idaho Department of Health and Welfare may, in its discretion, immediately terminate this Medicaid Provider agreement when the provider fails to comply with any term or provision herein. Said termination shall be in writing and shall be effective upon such notice. Provider also understands and agrees that their conduct may be subject to additional penalties or sanctions as defined in the Rules Governing Medical Assistance, *IDAPA 16.03.09.200 Provider Application Process* and Section 56-209h, Idaho Code.

7.3.1.2. Suspension of or failure to renew any license, certification, or insurance required by law to perform the services under this Medicaid Provider agreement shall result in immediate termination of this Medicaid Provider agreement without further notice.

7.3.2. Termination Without Cause: This Medicaid Provider agreement may be terminated by either party without cause by giving 30 days notice in writing to the other party.

7.4. Assignment: The provider shall not reassign this service agreement, nor any part thereof, nor any right to any monies to be paid to the provider under this Medicaid Provider agreement without the express written consent of IDHW.

7.5. Severability: If any provision of this Medicaid Provider agreement is found to be in conflict with any rule, or law, or statute of the state of Idaho or the United States, then such provision which may be in conflict shall be deemed inoperative, null and void, but shall not be deemed to effect the validity of the remaining provisions of this Medicaid Provider agreement.

7.6. Commencement: The term of this Medicaid Provider agreement shall begin on January 1, 2001, or the date signed and approved by IDHW, whichever is later.

The undersigned have read and understand this agreement and agree to be bound by the terms hereof:

For the Department:

Print Name

Title or Position

Signature

Date Signed

For the Provider:

Print Name

Title or Position

Signature

Date Signed

Signature-on-File

I hereby certify that I have compared the information submitted regarding materials furnished and services rendered against my records and that the foregoing information is true, accurate, and complete. I further certify that:

- The charges submitted for the material furnished and services rendered are correct charges against the state of Idaho pursuant to applicable IDHW regulations and state law.
- The claim is due.
- I am authorized to sign for the payee.
- Complete records of materials and services will be provided upon request to the Secretary of the United States Department of Health and Human Services, the Idaho Department of Health and Welfare, and the Medicaid Fraud and Program Integrity Unit.
- I accept payment as payment in full subject to adjustment in accordance with IDHW regulations.
- All materials furnished and/or services rendered have been provided without unlawful discrimination on the grounds of race, age, sex, creed, color, national origin, physical handicap, or mental handicap.

I understand that payment and satisfaction of all claims submitted with my signature will be from federal and state funds and that any falsification or concealment of material fact is subject to prosecution under applicable federal and state laws.

I agree and certify that, for all Medicaid claims submitted with the signature of:

_____,

the terms and conditions of the above statement have been met and will continue to be met.

Authorized Signature: _____

Title: _____

Name typed or printed: _____

Date: _____

The provider or responsible corporate official must sign this certificate statement.

Authorization for Electronic Funds Transfer

Complete all the sections below if you wish to have your payments automatically deposited to your bank. The transaction routing number can be obtained from your bank.

Important: You must include a letter from your bank verifying your transaction routing number and account number. For deposits to a checking account, you may instead include an original voided check or copy of a voided check. If you include a voided check, tape it in the space provided below. (Please, do not staple the check.)

Provider Name: _____

Bank Name: _____ **Bank Phone Number:** (____) _____

Bank Address: _____

Account Number: _____

Transaction Routing Number: (9-digit) _ _ _ _ _

Type of Account: (circle only one) **Checking** **Savings**

I authorize the electronic transfer of Idaho Medicaid payments made to the above provider. I understand that I am responsible for the validity of the above information.

Authorized Signature: _____ **Date:** _____

Name typed or printed: _____

**For checking account deposit
only, tape a voided check here.**

Electronic Claims Submission Certification and Authorization

_____, hereinafter referred to as 'provider', hereby certifies as follows:

(Provider name)

The provider certifies that all services and items for which reimbursement will be claimed shall be furnished by, or under the supervision of, the provider.

The provider understands that the use of electronic claims submission does in no way relieve the provider of responsibilities for (a) Maintaining such medical and fiscal records as are necessary to disclose fully the nature and extent of services or items provided by the provider to Medicaid recipients, and making such records available upon request to the Idaho Department of Health and Welfare (IDHW) and the United States Department of Health and Human Services; and (b) Promptly returning to IDHW, or its fiscal agent, the amount of any erroneous or excess payments received for services or items provided to any Medicaid recipients.

The provider certifies that the claim is due, that the provider is authorized to sign for the payee, that complete records of these services are being kept in hardcopy form for five years, and will be provided upon request. The provider accepts payment in full for the claims submitted subject to adjustment as authorized by IDHW regulations and certifies that these services have been rendered without unlawful discrimination on the grounds of race, age, sex, creed, color, national origin, physical or mental handicap. The provider certifies that if prescription services are provided, a legal prescription is on file for each medication issued.

The provider certifies that all services and items from which reimbursement will be claimed shall be provided in accordance with all federal and state laws pertaining to the Idaho Medicaid Program, and that all charges submitted for services and items provided shall not exceed provider's usual and customary charges for the same services and items when provided to persons not entitled to receive benefits under the Idaho Medicaid Program.

The provider understands that any payments made in satisfaction of claims submitted will be derived from federal and state funds and that any false claims, statements, documents, or concealment of material fact may be subject to prosecution under applicable federal and state law.

If the provider uses a billing service, the provider agrees to report completely and accurately to the billing service all information necessary to ensure compliance with federal and state laws pertaining to the Idaho Medicaid Program, as amended.

The provider understands that IDHW reserves the right to revoke its approval for electronic claims submission, at any time, for failure on the part of the provider or billing service to comply fully with any or all guidelines governing the submission of electronic claims.

The provider holds EDS harmless and indemnifies EDS against any liability to the provider, the state of Idaho, or to any Medicaid provider arising out of the entering into this agreement or subsequent receiving and processing of Medicaid claims by tape or other electronic media.

SECTION I

Idaho Department of Health and Welfare shall allow providers to enter Medicaid claims through the claims entry system developed by IDHWs fiscal agent and designated Electronic Claims Submission (ECS), through the use of entry screens developed by authorized computer vendors, by magnetic tape, or cartridge.

Both EDS and the state of Idaho must approve of any provider prior to the submission of electronic claims.

The provider shall allow IDHW access to claims data and assure that submission of claims data is restricted to authorized personnel so as to preclude erroneous payments resulting from carelessness or fraud.

Provider Name: _____

Provider Address: _____

City: _____ State: _____ Zip+4: _____

Phone Number: (____) _____

Authorized Signature: _____ Date: _____

Name printed or typed: _____

National Provider Identifier (NPI) to be linked to this Idaho Medicaid number: _____

SECTION II

(To be completed by providers using a billing service)

The provider agrees to abide by the policies affecting electronic submissions as published in the electronic specification manual for Medicaid claims.

The provider hereby certifies that _____ is authorized to

(Billing Service)

submit electronic claims on provider's behalf.

The provider agrees that if the billing arrangement with the aforementioned billing service is terminated, the provider will immediately report the termination in writing to IDHW or its fiscal agent.

Authorized Signature: _____ Date: _____

Name printed or typed: _____

Mail to:
EDS
Provider Enrollment
PO Box 23
Boise, ID 83707

Fax to:
EDS
Attn: Provider Enrollment
(208) 395-2198

Information:
(800) 685-3757
Ask for *Provider Enrollment*

Disclosure of Ownership and Control Interest Statement

Providers must disclose to the Division of Medicaid Agency the following information:

- 1** Enter the legal name of your business: _____
- 2** Check (✓) the applicable business category:
☐ Sole Proprietor ☐ Corporation ☐ Partnership ☐ Limited Liability Corporation
☐ Government
- 3** **A)** List the name and address of each person with an ownership or control interest in the disclosing entity or any subcontractor in which the disclosing entity has direct or indirect ownership of five percent or more (42 CFR §§ 455.104).
B) List any board members not already listed.
C) Indicate with a check (✓) in the applicable column if the person listed has ever been sanctioned, excluded, or convicted of a criminal offense related to Medicare, Medicaid, or any federal agency or program (42 CFR §§ 455.106).

A & B	C		
	Sanctioned	Excluded	Convicted
Name and Address			

- 4** Are any of the persons named above related as spouse, parent, child or sibling to any of the other persons named? ☐ Yes ☐ No If Yes, provide name(s) of person(s) and relationship(s).

- 5** Do any of the persons listed in # 3 have ownership or control interest of five percent or more in other organizations that bill Medicaid for services? ☐ Yes ☐ No If Yes, provide the following for each organization.

Organization Legal Business Name	FEIN	Medicaid Provider Number

Provider Signature

Date

Attachments

Depending on your provider specialty, you are required to include certain attachments with this application packet. Do not send original documents. It is the provider's responsibility to have valid documentation for all dates of service.

Providers that will not actually be transporting participants are exempt from the vehicle liability insurance requirement (for example, lodging and meals only, purchased bus passes or tickets, purchased airline tickets, attendant care, etc.). In order to claim this exemption, the provider must include a statement that they will not be submitting Medicaid claims for transporting participants.

Note: If automobile liability insurance is not in the name of the applicant, an explanation is required.

Commercial Transportation Provider (specialty code 109)

Advertises and provides transportation to the general public, has an established rate schedule, serves all people in the community, as well as Medicaid participants. Examples are cab and bus companies. Providers that are members of the hospitality industry are exempt from having to provide any attachments. This includes travel agencies, car rental agencies, motels, and restaurants.

- Description of marketing efforts and example of advertisements to the general public (such as yellow page or newspaper ads, brochures, etc.).
- Rate schedule of usual and customary fees charged to the general public.
- A copy of the cover sheet for automobile liability insurance policy. This cover sheet must show:
 - The insurance is at least \$500,000 for bodily injury or death and \$500,000 for property damage (or \$1,000,000 combined).
 - The coverage dates of the policy include the dates of services billed to Medicaid.
 - Medicaid Transportation Unit must be listed as an "additional insured" on the certificate of insurance.

Note: The provider must give their insurance company the following name and address to be included as additional insured:

Medicaid Transportation Unit

PO Box 83720

Boise, ID 83720-0036

- A copy of the driver's license for each individual listed on the Drivers Roster, page 4 of the Non-Emergency Transportation Provider application.
- A copy of the vehicle registration for each vehicle listed on the Vehicle Roster, page 5 of the Non-Emergency Transportation Provider application .

Non-Commercial Individual Transportation Provider (specialty code 110)

Drives a limited number of Medicaid participants, often a family member. Examples are parents or children of Medicaid participants.

- Copy of the cover sheet for automobile liability insurance policy for the person that will be providing transportation services. This cover sheet must show that the coverage dates of the policy include the dates of services billed to Medicaid

Non-Commercial Agency Transportation Provider (specialty code 111)

Provides transportation to Medicaid participants served by the agency. Examples are treatment centers, nursing homes, hospitals, and personal care service agencies.

- Copy of auto liability insurance policy cover sheet indicating the coverage for their cars and drivers. This cover sheet must show:
 - The insurance is at least \$100,000 per person and \$300,000 per occurrence.
 - The coverage dates of the policy include the dates of services billed to Medicaid.

Note: If an agency has its employees use their personal vehicles, and does not wish to have an auto liability insurance policy covering its employees, the agency cannot enroll as an agency transportation provider. The individual employees must enroll and bill as individual transportation providers.

Note: State agencies are exempt from this requirement.

W-9

**Request for Taxpayer
Identification Number and Certification**

**Give form to the
requester. Do not
send to the IRS.**

Print or type
See Specific Instructions on page 2.

Name (as shown on your income tax return)

Business name, if different from above

Check appropriate box: ☐ Individual/Sole proprietor ☐ Corporation ☐ Partnership
☐ Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶
☐ Other (see instructions) ▶

☐ Exempt
payee

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number

or

Employer identification number

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. See the instructions on page 4.

**Sign
Here**

Signature of
U.S. person ▶

Date ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,

- The U.S. grantor or other owner of a grantor trust and not the trust, and
- The U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person, do not use Form W-9. Instead, use the appropriate Form W-8 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.
4. The type and amount of income that qualifies for the exemption from tax.
5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester the appropriate completed Form W-8.

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 28% of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,
2. You do not certify your TIN when required (see the Part II instructions on page 3 for details),
3. The IRS tells the requester that you furnished an incorrect TIN,

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions below and the separate Instructions for the Requester of Form W-9.

Also see *Special rules for partnerships* on page 1.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of \$50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a \$500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Name

If you are an individual, you must generally enter the name shown on your income tax return. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first, and then circle, the name of the person or entity whose number you entered in Part I of the form.

Sole proprietor. Enter your individual name as shown on your income tax return on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name" line.

Limited liability company (LLC). Check the "Limited liability company" box only and enter the appropriate code for the tax classification ("D" for disregarded entity, "C" for corporation, "P" for partnership) in the space provided.

For a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Regulations section 301.7701-3, enter the owner's name on the "Name" line. Enter the LLC's name on the "Business name" line.

For an LLC classified as a partnership or a corporation, enter the LLC's name on the "Name" line and any business, trade, or DBA name on the "Business name" line.

Other entities. Enter your business name as shown on required federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name" line.

Note. You are requested to check the appropriate box for your status (individual/sole proprietor, corporation, etc.).

Exempt Payee

If you are exempt from backup withholding, enter your name as described above and check the appropriate box for your status, then check the "Exempt payee" box in the line following the business name, sign and date the form.

Generally, individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends.

Note. If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.

The following payees are exempt from backup withholding:

1. An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2),
 2. The United States or any of its agencies or instrumentalities,
 3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities,
 4. A foreign government or any of its political subdivisions, agencies, or instrumentalities, or
 5. An international organization or any of its agencies or instrumentalities.
- Other payees that may be exempt from backup withholding include:
6. A corporation,
 7. A foreign central bank of issue,
 8. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States,
 9. A futures commission merchant registered with the Commodity Futures Trading Commission,
 10. A real estate investment trust,
 11. An entity registered at all times during the tax year under the Investment Company Act of 1940,
 12. A common trust fund operated by a bank under section 584(a),
 13. A financial institution,
 14. A middleman known in the investment community as a nominee or custodian, or
 15. A trust exempt from tax under section 664 or described in section 4947.

The chart below shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 15.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt payees except for 9
Broker transactions	Exempt payees 1 through 13. Also, a person registered under the Investment Advisers Act of 1940 who regularly acts as a broker
Barter exchange transactions and patronage dividends	Exempt payees 1 through 5
Payments over \$600 required to be reported and direct sales over \$5,000 ¹	Generally, exempt payees 1 through 7

¹ See Form 1099-MISC, Miscellaneous Income, and its instructions.

² However, the following payments made to a corporation (including gross proceeds paid to an attorney under section 6045(f), even if the attorney is a corporation) and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, and payments for services paid by a federal executive agency.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-member LLC that is disregarded as an entity separate from its owner (see *Limited liability company (LLC)* on page 2), enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

Note. See the chart on page 4 for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local Social Security Administration office or get this form online at www.ssa.gov. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at www.irs.gov/businesses and clicking on Employer Identification Number (EIN) under Starting a Business. You can get Forms W-7 and SS-4 from the IRS by visiting www.irs.gov or by calling 1-800-TAX-FORM (1-800-829-3676).

If you are asked to complete Form W-9 but do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note. Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 4, and 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). Exempt payees, see *Exempt Payee* on page 2.

Signature requirements. Complete the certification as indicated in 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account ¹
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor ²
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee ¹
b. So-called trust account that is not a legal or valid trust under state law	The actual owner ¹
5. Sole proprietorship or disregarded entity owned by an individual	The owner ³
For this type of account:	Give name and EIN of:
6. Disregarded entity not owned by an individual	The owner
7. A valid trust, estate, or pension trust	Legal entity ⁴
8. Corporate or LLC electing corporate status on Form 8832	The corporation
9. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
10. Partnership or multi-member LLC	The partnership
11. A broker or registered nominee	The broker or nominee
12. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity

¹ List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

² Circle the minor's name and furnish the minor's SSN.

³ You must show your individual name and you may also enter your business or "DBA" name on the second name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

⁴ List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships* on page 1.

Note. If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Secure Your Tax Records from Identity Theft

Identity theft occurs when someone uses your personal information such as your name, social security number (SSN), or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

Call the IRS at 1-800-829-1040 if you think your identity has been used inappropriately for tax purposes.

Victims of identity theft who are experiencing economic harm or a system problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

Protect yourself from suspicious emails or phishing schemes.

Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to phishing@irs.gov. You may also report misuse of the IRS name, logo, or other IRS personal property to the Treasury Inspector General for Tax Administration at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at: spam@uce.gov or contact them at www.consumer.gov/idtheft or 1-877-IDTHEFT(438-4338).

Visit the IRS website at www.irs.gov to learn more about identity theft and how to reduce your risk.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons who must file information returns with the IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA, or Archer MSA or HSA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice for civil and criminal litigation, and to cities, states, the District of Columbia, and U.S. possessions to carry out their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 28% of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.